

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

4/29/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/26/2013 – 4/26/2013
MAXIMUS IBR Case: CB13-0000667

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/2/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$0.00, for a total of \$0.00.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule or negotiated contract: PPO Contract
- Other: OMFS Surgery General Information and Ground Rules, CPT coding guidelines

Supporting Analysis:

The dispute regards the payment amount for removal of spinal cord stimulator test lead (63660 and 63660 Modifier 59). The Claims Administrator reimbursed a total of \$75.00 for the billed procedure codes 63660 and 63660 Modifier 59) on the initial explanation of review. The Claims Administrator issued an additional \$691.60 on explanation of review in response to the Provider's Appeal.

The Claims Administrator sent MAXIMUS a letter dated 1/9/2014, indicating the Claims Administrator reimbursed the Provider an additional amount of \$383.30 for the billed procedure codes (63660 and 63660 Modifier 59) for date of service 4/26/2013 and the Independent Bill Review application fee of \$335.00. The additional payment by the Claims Administrator was issued after the Independent Bill Review case was assigned by MAXIMUS. The IBR application was assigned on 12/2/2013. The additional payment of \$383.30 was issued on 12/6/2013. The Provider submitted a letter to MAXIMUS, indicating the Claims Administrator paid an additional \$383.30 on the billed services in dispute and the application fee of \$335.00, Provider indicated they were not withdrawing the application.

CPT 63660 – Revision or removal of spinal neurostimulator electrodes
Modifier 59 – Distinct Procedural Services

Per coding guidelines, procedure code 63660 can be separately reported for removal of any additional electrode catheter(s) or plate(s)/paddle(s) by appending either modifier 51 (same anatomic site) or modifier 59 (different anatomic site) to the appropriate code. An array is a collection of electrical contacts on a single catheter, plate, or paddle. All neurostimulator electrode arrays have leads with multiple contact electrodes. The operative report documented the procedures performed as: Spinal cord stimulator test lead removal times two. Reimbursement is warranted for the billed procedure codes 63660 and 63660 Modifier 59.

The Provider billed two surgical procedure codes (63660, 63660 Modifier 59) for date of service 4/26/2013. Based on multiple surgery guidelines, the CPT 63660 is the primary procedure and reimbursement is based on 100% of the listed value and CPT 63660 Modifier 59 is considered the second highest valued or equivalent procedure and should be reimbursed at 50% of the listed allowance.

Based on a review of the final explanation of review dated 12/6/2013, it appears the PPO allowance for the billed procedure codes was based on OMFS allowance for procedure code 63660. The OMFS allowance for procedure code 63660 is listed as \$1,075.59. The explanation of review indicates a payment of \$766.60 and a PPO discount of \$308.99 for the primary surgical procedure code 63660; and a payment of \$383.30 and a PPO discount of \$154.50 for the second billed surgical procedure code 63660 Modifier 59. Per the final EOR, the disputed billed procedure codes were paid in full up to the Official Medical Fee Schedule allowance minus the PPO discount.

Based on the documentation submitted, additional reimbursement was warranted for the Official Medical Fee Schedule codes 63660 and 63660 Modifier 59. Due to the application fee of \$335.00 and PPO allowance for the billed surgical procedures being paid in full prior to the IBR Final Determination decision, the amount owing by the Claims Administrator is \$0.00.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
63660		1	\$423.39	\$766.60	\$766.60	\$0.00	PPO Contract
63660	59	1	\$423.39	\$383.30	\$383.30	\$0.00	PPO Contract

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 63660 and 63660 Modifier 59 (\$0.00) for a total of \$0.00.

The Claims Administrator is required to reimburse the provider \$0.00 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

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